Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. STEPHEN E. EARLE

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-14-2065-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Codes 63044-50, 63662-59, 63042-50, 63044-59 were denied on the basis that 'the procedure/service was not documented.' Please see that attached operative report for the descriptive detail of each procedure.

Codes 22830-22852-59, were denied on the basis that they were 'included in another billed procedure' or 'procedure/service is not paid separately.' Per the Mutually Inclusive Table established by CMS and updated monthly, none of the codes reported for this date of service are mutually inclusive.

Code 22899-99 was denied on the basis that the code reported was not the appropriate procedure code. 22899-99 represents examination under anesthesia. Please see the operative report for documentation of the procedure.

Code 63011 was denied because the procedure had reached the maximum allowed units. Per the NCCI Edits Table established by CMS, code 63011 is allowed one time. Code 63011 was not paid at all. "

Amount in Dispute: $14,825.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's charges were denied for the following reason:

63044-59 $1125.00 – There was no documentation to support any procedures were done in excess of what would be done to perform the arthrodesis CPT 22612…63011-22 $2550.00 – There is no documentation to support a decompression in excess of what would be done to perform the arthrodesis. NCCI also identifies exploration of a site where surgery is performed is not billed separately. This was performed at the L5-S1 and a revision was also performed at this level during this operative setting. 22852-59 $3750.00 – Provider was paid 673.47 for this code as per the fee schedule allowable. However 22852-22 $2500.00 was denied as the CPT code 22852 covers the removal of the posterior instrumentation, the code is not allowable as a bilateral procedures and isn't allowable for a second unit billed unless an entirely different area of the spine was treated, in this case it was the same area…22830-59 $1500.00 – Operative reports supports exploration was performed at L4-S. Operative report also supports revisions were performed L4-S1. Exploration is not billed separately when performed at the same level as the surgical procedure. This would be inappropriate use of the Modiifer-59 being appended. 63662-59 $1125.00 – This code is for the removal of spinal neurostimulator…This was also performed at the same levels as the revision surgery was performed…22899-99 $550.00 – Unlisted code for examination under analgesia…is not billed separately. 63042-50 $3100.00 – There was no documentation to support any procedures were done in excess of what would be done to perform the arthrodesis CPT 22612…63044-59 $3100.00 – There was no

documentation to support any procedures were done in excess of what would be done to perform the arthrodesis CPT 22612."

Response submitted by: Coventry Workers' Comp Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2013	CPT Code 63044-50 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	$1,125.00	$0.00
	CPT Code 63011-22 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral	$2,550.00	$0.00
	CPT Code 22852-59 Removal of posterior segmental instrumentation	$3,750.00	$0.00
	CPT Code 22830 Exploration of spinal fusion	$1,500.00	$0.00
	CPT Code 63662-59 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$1,125.00	$0.00
	CPT Code 22899-99 Unlisted procedure, spine	$550.00	$0.00
	CPT Code 63042-50 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	$3,100.00	$0.00
	CPT Code 63044-59 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	$1,125.00	$0.00
TOTAL		$14,825.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical necessity/preauthorization dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P304-Line paid at 100 percent of billed charges.
   - 150-Payer deems the information submitted does not support this level of service.
   - V123-CV: Medical documentation provided does not support the service or level of service billed.

- U849-The multiple procedure reduction was reduced 50% according to fee schedule or Fair Health benchmark data.
- 59-Processed based on multiple or concurrent procedure rules.
- W1-Workers compensation state fee schedule adjustment.
- P300-The amount paid reflects a fee schedule reduction.
- V129-Procedure is included in global value of another procedure.
- 97-The benefit for this service is included in the payment/allowance of another procedure.
- 125-Submission/billing error(s).
- X091-Payment for this charge is not recommended without an appropriate procedure code or description of service.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the submitted documentation support billing of CPT codes 63042-50, 63044-50, and 63044-59? Is the requestor entitled to reimbursement?
2. Does the submitted documentation support billing of CPT code 63011-22? Is the requestor entitled to reimbursement?
3. Is the requestor entitled to reimbursement for CPT code 22852-59?
4. Is the allowance of CPT code 22830 included in the allowance of another service/procedure billed on the disputed date of service?
5. Does the submitted documentation support billing of CPT code 63662-59? Is the requestor entitled to reimbursement?
6. Does the submitted documentation support billing of CPT code 22899-99? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 63042-50, 63044-59 and 63044-50 based upon service/procedure was not documented.

   On the disputed date of service, the requestor billed codes 63044-22, 63011-22, 63011-59, 22852-22, 22852-59, 22830-59, 20937, 22612, 22614, 20930, 63662-22, 63662-59, 22614-59,22899-99, 63042, 63042-50, 63044, 63044-50, and 63044-59.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   - CPT code 63042 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar."
   - CPT code 63044 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)."

   The requestor appended modifier "50-Bilateral Procedure" to codes 63042 and 63044. Modifier "59-Distinct Procedural Service" was appended to code 63044.

   The requestor billed 63042, 63042-50, 63044, 63044-50 and 63044-59. A review of the Operative Report indicates "The patient then underwent revision lumbar spine surgery at L5-S1 bilaterally, L4-L5 bilaterally, L3-L4 bilaterally and revision of sacral spine surgery at the first sacral interval bilaterally. This revealed no impingement of the thecal sac or nerve roots. There was no pedicle defect." The Division finds that the requestor did not support billing CPT code 63042 and 63044. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT 63011-22 based upon a lack of documentation.

CPT code 63011 is defined as “Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral.”

The requestor appended modifier “22-Increased Procedural Services” to code 63011. Modifier 22 is defined as “When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).” A review of the operative report does not document the “increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required” to support billing modifier 22.

A review of the Operative report does not support billing code 63011. As a result, reimbursement is not recommended.

3. The respondent paid $673.47 for code 22852-59 based upon the fee schedule. A review of the Operative report supports hardware removal.

   A review of the submitted medical billing indicates that the requestor billed 22852-22 and 22852-59. The requestor appended modifier “59-Distinct Procedural Service” to CPT code 22852.

   ‘‘Modifier 59 is defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.” A review of the operative report does not support “a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual;” therefore, the requestor did not support using modifier 59. In addition, the requestor did not support billing code 22852 twice.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2013 DWC conversion factor for this service is 69.43.

   The Medicare Conversion Factor is 34.023

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78233, which is located in Live Oak; therefore, the Medicare participating amount is based on locality “Rest of Texas”.

   The Medicare participating amount for code 22852 is $660.05.

   Using the above formula, the MAR is $1,346.94; however, this code is subject to multiple procedure rule discounting = $673.47. The respondent paid $673.47; therefore, no additional reimbursement is recommended.

4. According to the explanation of the respondent denied reimbursement for CPT code 22830 based upon reason code “97.”

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, CPT code 22830 is a component of CPT code 22612; however, a modifier is allowed to differentiate the service. A review of the submitted medical billing finds that the requestor appended modifier "59-Distinct Procedural Service" to CPT code 22830.

"Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used." A review of the operative report does not support "a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual;" therefore, the requestor did not support using modifier 59. As a result, no reimbursement is recommended.

5. According to the explanation of the respondent denied reimbursement for CPT code 63662-59 based upon a lack of documentation to support billed service.

   CPT code 63662 is defined as "Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed." A review of the Operative report does not indicate that a laminotomy or laminectomy, including fluoroscopy was performed; therefore, the requestor has not supported billing code 63662. As a result, no reimbursement is recommended.

6. The Requestor billed CPT code 22899-99 –"Unlisted procedure, spine."

   - The requestor appended modifier "99-Multiple Modifiers" to CPT code 22899.
   - The respondent denied reimbursement for this service based upon reason codes "125 and X091."
   - The requestor wrote in the position summary that "22899-99 represents examination under anesthesia."
   - The Respondent wrote "Unlisted code for examination under analgesia…is not billed separately."

   The Division finds the following:

   - The requestor did not submit a copy of the examination under anesthesia and pain study to support the billed study.
   - CPT code 22899 does not have a listed relative value unit or payment assigned by Medicare; therefore, this code is subject to fair and reasonable reimbursement per 28 Texas Administrative Code §134.203(f).
   - 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement)." Review of the submitted documentation finds:

     - The requestor does not discuss or explain how reimbursement of $500.00 for code 22899-99 is a fair and reasonable reimbursement.
     - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
     - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
     - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

     The request for reimbursement is not supported. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/13/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.